HISTORY

104 The Dermatologic History

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Definition

To the dermatologist, the history of the disorder is of less importance than the physical examination. Because skin lesions are visible, the patient is more likely to draw his or her own, often erroneous, conclusions regarding the development of the problem. The likelihood is also extremely high that the patient has attempted to alter the course of the skin problem by applying some type of medication to the area, and this may affect what the doctor is able to see when the patient presents to the office. The purpose of the dermatologic history is: (1) to allow the patient to verbalize the complaint and develop a rapport with the physician; (2) to determine factors that may have set off or aggravated the problem; (3) to determine the course of the disorder, whether it is acute or chronic; (4) to determine whether there are associated systemic complaints. Probably the single most important question that should be asked is the duration of the disorder.

Technique

Initially, the history should be brief and limited to the duration and location of the cutaneous disorder. The dermatologic database should also include the age, skin shade, sex, and occupation of the patient. Upon completion of the physical examination, a more appropriate, detailed, and relevant history may be obtained. Sometimes it is more helpful to ask questions than to allow the patient to give a long, rambling account of the progression of the disorder. The physician must be beware of being too quick to make a diagnosis, for this will introduce bias and make it less likely that relevant parts of the patient's history will be noted that might subsequently cause the clinician to change an opinion.

Inquiry into the original appearance of the lesion is important, for it may have been altered by the patient's scratching or topical therapy. Remember, though, that patients do not always use correct medical terminology in describing lesions; they may, for example, refer to a papule as a "blister" or a "bump." The physician may need to seek clarification by inquiring, "You mean a bump like a mosquito bite, or a blister that would leak clear fluid if you stuck it?" Lesions do not arise *de novo* as ulcers or erosions. The patient's insistence that this is so may represent an unwillingness to admit to manipulation of the lesion.

Probably the most common symptom in dermatology is itching, or pruritus. This can usually be confirmed on examination of the skin for the appearance of scratch marks or excoriations. A patient who complains of itching without evidence of excoriation may actually be asking the physician to examine the skin closely. The patient may fear cancer or parasites but is reluctant to ask about this possibility.

Especially important is a history of previous therapy. Phrasing is important in asking this question, for a doctor who says, "You haven't put anything on your skin, have you?" will be met with a vigorous negative shake of the patient's head. The nonjudgmental invitation, "Tell me everything you've been using on your skin," is more apt to elicit a long list of medications acquired from the drugstore, the neighbors, and possibly other physicians. One should assume a long list and ask, "What else?"

While stress may indeed worsen the patient's response to a dermatologic condition, it is not necessarily a significant factor in the development of a particular disorder. It is important to inquire, however, what has brought the patient to the physician at this particular time. It may be that a loved one has insisted that the patient inquire about a particular lesion, or the patient may fear a venereal disease of some sort. Obtaining this important aspect of the history will enable the physician to discuss the patient's concern and make appropriate therapeutic intervention much more likely. If it can be stated truly, patients should be specifically reassured that the skin problem is neither contagious nor their fault. Many patients, for example, fear that their skin problem is due to "dirt" or lack of cleanliness, and may even have worsened their condition by misguided attempts to scrub out a supposed infection.

Inquiry into the patient's medications is also important, as is the length of time a given medicine has been taken. Some drugs are notorious for causing skin problems (allopurinol, penicillin), and the fact that a patient has taken a given drug for many years does not lessen the likelihood that it is an offending agent. The drug history is also helpful in determining other systemic problems for which the patient is undergoing treatment. Patients are not always aware of their medical diagnosis, but they can frequently give the names of their medications, enabling the astute physician to guess the underlying diagnosis correctly. Drug reactions may mimic other conditions as well, and this element of the medical history is becoming increasingly important in evaluating the patient's total health picture.

Asking about the presence of similar disorders in other members of the household is obviously important when infectious diseases are considered (scabies, impetigo, varicella, herpes). Some dermatologic conditions are hereditary, though, and clues to unusual disorders with relatively common presentations may be suspected by their occurrence in other family members.

Basic Science and Clinical Significance

Details of age and skin type are important in adding or eliminating certain diagnoses as likely possibilities. For example, a long history of exposure to sunlight would increase the risk for a fair-skinned patient to develop skin cancer, while a black patient with a similar history would be at much less risk for the same problem. Occupation-related aspects of the history include foreign travel and exposure to sensitizers in the workplace or home environment.

Hobbies or travel habits may give clues to the etiology of unusual disorders, such as infectious diseases not endemic to the area where the patient lives. Common seasonal problems such as insect bites may be seen in the winter in a patient who has recently traveled to a warm, insect-infested environment on vacation. Gardening activities, with the chance of exposure to unusual plants, and hobbies involving chemicals (photographic developers, epoxies) are also suspect.

Symptoms of pruritus, pain, or burning are subjective, but may be helpful in differentiating between two similar disorders. The degree of discomfort does not necessarily correlate with the seriousness of the condition. Many skin cancers are asymptomatic, while benign tumors can be extremely painful. Because of the location of cutaneous nerves, certain areas of the body are more likely to be painful than others. It is also true that patients may exaggerate their symptoms in order to convince the physician that treatment is imperative.

Dermatologic disorders can be markedly altered by therapy, both for good and ill. A mild over-the-counter steroid preparation can remove scales from a plaque of psoriasis, or the application of a neomycin-containing topical antibiotic may lead to the development of an eczematous, oozing contact dermatitis that will obscure the underlying morphology of a totally different condition. The response to a previous therapy may be extremely helpful in differential diagnosis. Patients will sometimes express reluctance to name specific medications saying, "I've tried 'em all, and nothing helped." Asking the patient to list medications specifically, or better yet, to bring in the assortment of tubes and jars, may reveal that all therapy to date has been a variation of topical steroids, and the patient has never received a topical antifungal for an obvious tinea infection.

The association of dermatologic disorders with systemic disease should always be considered. Some of these may be a direct result of the skin condition; for example, inguinal lymphadenopathy is not uncommonly found in a patient with chronic stasis dermatitis. The patient with systemic lupus erythematosus may complain of arthritis, and the recent onset of generalized scaling or ichthyosis should prompt inquiry into other signs of internal malignancy, such as weight loss. Inquiry into seasonal exacerbations of skin disease are probably most important in the photosensitive disorders, which worsen in summer. Other disorders, such as atopic dermatitis, are somewhat idiosyncratic; some patients worsen in winter and others in summer.

Psoriasis and atopic dermatitis are two well-known familial skin disorders, but there are subtle degrees of penetrance in many other conditions, making the family history important. Hailey–Hailey disease (benign familial pemphigus), for example, may resemble simple intertrigo. The chronicity of the clinical course of this disorder and its occurrence within a family should raise the physician's suspicions enough to obtain a confirmatory skin biopsy, a procedure seldom performed when managing intertrigo. Some disfiguring and disabling hereditary skin conditions, such as severe forms of ichthyosis, can be diagnosed in utero when the diagnosis is suspected early in pregnancy.

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